CVS CAREMARK

Your Prescription Benefit

PLAN C
Prescription Drug Benefit Description
Herein called "Description"

Plan C Prescription Drug Program For State of Kansas Employees Health Plan
This booklet describes the Plan C Prescription Drug benefits available through the State of Kansas program. The prescription drug program is funded by the Kansas State Employees Health Care Commission and administered by CVS/caremark. The State of Kansas reserves the right to change or terminate the program at any time or to change the company that administers the program.

The CVS/caremark Pharmacy and Therapeutics Committee administers the Preferred Drug List and assists the State in determining the appropriate tiers of coverage. CVS/caremark is not the insurer of this Program and does not assume any financial risk or obligation with respect to claims.

Contact Information
For answers to any questions regarding
Your prescription claims payment contact:

CVS/caremark
P.O. Box 52136
Phoenix, Az 85072-2136
1-800-294-6324
http://www.caremark.com

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Section 1 *Definitions*

Allowed Charge – the maximum amount the Plan determines is payable for a covered expense. For this Plan the Allowed Charge will be the contracted reimbursement rate including any applicable sales tax. When this Plan is secondary to other insurance coverage, the Allowed Charge will be the amount allowed but not covered by the other plan subject to the coverage provisions of this Plan.

Brand Name – Typically, this means a drug manufactured and marketed under a trademark, or name by a specific drug manufacturer. For purposes of pricing, drug classification (e.g., Brand vs. Generic) will be established by a nationally recognized drug pricing and classification source.

Compound Medication – a medication mixed for a specific patient and not available commercially. To be eligible for reimbursement a Compound Medication must contain at least one Legend Drug that has been assigned a national drug code (NDC) number, requiring a Physician's Order to dispense, and eligible for coverage under this Plan.

Coinsurance – is a sharing mechanism of the cost of health care and is expressed as a percentage of the Allowed Charge that will be paid by You and the balance paid by the Plan.

Copayment – a specified amount that You are required to pay for each quantity or supply of prescription medication that is purchased.

Copayment/Coinsurance Maximum – the maximum combined total for a Member on the Coinsurance and Copayments for Generic, Preferred and Special Case Medications.

Discount Medications – are medications Not Covered by the Plan but the Plan has negotiated discounts from Network Pharmacies for their purchase. These items include medications with primary indications for use are: infertility; erectile dysfunction; medications used primarily for cosmetic purposes; dental preparations (toothpaste, mouthwash, etc.); prescription medications where an equivalent non prescription product is available Over-The-Counter - example: non sedating antihistamines & nasal steroids; Drug Efficacy Study Implementation (DESI-5) medications – older medications which still require a prescription, but which the FDA has approved only on the basis of safety, not safety and effectiveness; Ostomy supplies and other prescription medications designated by the Plan.

Drug Override – a feature that allows Members who meet specific criteria outlined in the Plan to receive Non Preferred Drugs at the Preferred Drug Coinsurance level.

Experimental, Investigational, Educational or Unproven Services – medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Plan (at the time it makes a determination regarding coverage) to be: **(1)** not approved by the U.S. Food and Drug Administration

("FDA") to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopeia Dispensing Information as appropriate for the proposed use; or **(2)** subject to review and approval by any Institutional Review Board for the proposed use; or **(3)** the subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, or 3 Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or **(4)** not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed; or **(5)** for the primary purpose of providing training in the activities of daily living, instruction in scholastic skills such as reading or writing, or preparation for an occupation or treatment for learning disabilities.

Generic – Typically, this means a medication chemically equivalent to a Brand Name drug on which the patent has expired. For purposes of pricing, drug classification (e.g., Brand vs. Generic) will be established by a nationally recognized drug pricing and classification source.

Health Plan Deductible – The amount You are required to pay out of Your pocket before eligible medical or prescription drug claims will be reimbursed by the Plan.

Injectable Drug List – Injectable medications includes drugs that are intended to be self-administered by the Member and /or a family member as well as some that may need to be administered by a medical professional. The cost to inject these drugs is not covered under this Plan. Coverage is limited to those medications that have been designated by the Plan. This list is subject to periodic review and modification.

Legend Drug – medications or vitamins that by law require a physician's prescription in order to purchase them.

Maximum Allowable Cost List (MAC List) – a list of specific multi-source Brand Name and Generic drug products that the maximum allowable costs have been established on the amount reimbursed to pharmacies.

Maximum Allowable Quantity List – some medications are limited in the amount allowed per fill. Limiting factors are FDA approval indications for (MAQ) as well as manufacture package size and standard units of therapy. The list is subject to periodic review and modification.

Medically Necessary – Prescription Drug Products which are determined by the Plan to be medically appropriate and: **(1)** dispensed pursuant to a Prescription Order or Refill; **(2)** necessary to meet the basic health needs of the Member; **(3)** consistent in type, frequency and duration of treatment with scientifically-based guidelines of national medical, research, or health care coverage organizations or governmental agencies; and **(4)** commonly and customarily recognized as appropriate for treatment of the illness, injury, sickness or mental illness. **(5)** For Non Covered Prescription Drug Products to be considered for coverage, You must have had an unsuccessful trial with one or more prescription drug listed on the Preferred Drug List for treatment of the condition. Non Covered Prescription Drug Products require Prior

Authorization by the Plan and must meet all of the above Medical Necessity criteria to be considered for coverage. Your physician must contact the Plan to obtain Prior Authorization before a Non Covered Prescription Drug Product is eligible for coverage. The fact that a provider prescribed a Prescription Drug Product or the fact that it may be the only treatment for a particular illness, injury, sickness or mental illness does not mean that it is Medically Necessary. The fact that a medication may be medically necessary or appropriate does not mean that is a covered service.

Member – an individual eligible for benefits under the Plan as determined by the Plan Sponsor.

Network Pharmacy – a pharmacy that has entered into an agreement with CVS/caremark to provide Prescription Drug Products to Members and has agreed to accept specified reimbursement rates.

Non Covered – Prescription Drug Products for which reimbursement by the Plan is not available. The decision as to what Prescription Drug Products are not covered is determined by the Plan and subject to periodic review and modification.

Non Network Pharmacy - a pharmacy that has not entered into an agreement with CVS/caremark to provide Prescription Drug Products to Members or agreed to accept the CVS/caremark reimbursement rates

Non Preferred Drug – Covered FDA approved prescription drug products that are not listed on the Preferred Drug List and are not considered to be Non Covered drugs by the Plan.

Out of Pocket Maximum – The annual limit of a Member's payments for Covered prescriptions drugs and Services, as specified in the Health Plan Schedule of Benefits. The Out of Pocket Maximum includes Deductible, Coinsurance and Copayments for eligible medical and pharmacy expenses paid by the member.

Over The Counter (OTC) – are drugs You can buy without a prescription from a health care provider. The U.S. Food and Drug Administration ("FDA") determines whether medications are prescription or nonprescription. Nonprescription or OTC drugs are medications the FDA decides are safe and effective for use without a prescription.

Patient Assistance Programs - Pharmaceutical manufacturers may sponsor patient assistance programs that provide financial assistance to individuals to augment any existing prescription drug coverage. Amounts paid through these patient assistance programs will not count toward meeting Plan Deductibles or Out Of Pocket Maximums. Patient Assistance Programs may include copay cards, coupons and other such manufacturer sponsored assistance programs.

Performance Drug List - encourages members to use lower cost generics before using Non Preferred brand products for treatment with long-lasting reduction of gastric [stomach] acid production (PPIs –proton pump inhibitors.)

Before a prescription for a Non Preferred drug You must have tried one of the generic alternatives available for treating long- lasting reduction of gastric [stomach] acid production (PPIs – proton pump inhibitors.)

Pharmacy – a licensed provider authorized to prepare and dispense drugs and medications. A Pharmacy must have a National Association of Boards of Pharmacy identification number (NABP number).

Plan – The benefits defined herein and administered on behalf of the State of Kansas by CVS/caremark.

Plan Sponsor – State of Kansas

Preferred Drug List – a list that identifies those Prescription Drug Products that are preferred by the Plan for dispensing to Members when appropriate. This list is subject to periodic review and modification. The Preferred Drug List is available at: **http://www.caremark.com**.

Preferred Drug – a drug listed on the Preferred Drug List.

Prescription Drug Product – a medication, product or device registered with and approved by the U.S. Food and Drug Administration ("FDA") as safe and effective when used under a health care provider's care and dispensed under federal or state law only pursuant to a Prescription Order or Refill. For the purpose of coverage under the Plan, this definition includes insulin and diabetic supplies: insulin syringes with needles, alcohol swabs, blood testing strips-glucose, urine testing strips-glucose, ketone testing strips and tablets, lancets and lancet devices.

Prescription Order or Refill – the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

Prior Authorization – the process of obtaining pre-approval of coverage for certain Prescription Drug Products, prior to their dispensing, and using guidelines approved by the Plan Sponsor. The Plan retains the final discretionary authority regarding coverage. The list of medications requiring prior authorizations is subject to periodic review and modification.

Specialty Drugs - Utilized by a small percentage of the population with rather complex and/or chronic conditions requiring expensive and/or complicated drug regimens that require close supervision and monitoring on an ongoing basis. Specialty Drugs may require specialized delivery and are administered as injectable, inhaled, oral or infusion therapies. Coverage under the drug Plan is limited to medications that have been designated by the Plan as Specialty Drugs and are either self-administered or self-injectable. To be eligible for coverage under the Plan, Specialty Drugs must be purchased from the CVS/caremark Specialty Mail Order Pharmacy. This list of Specialty Drugs is subject to periodic review and modification.

Standard Unit of Therapy – a manufacturer's pre-packaged quantity or an amount sufficient for one course of treatment at normal dosages.

Tobacco Control – a program that encourages members to discontinue using tobacco products and reduce the risk of disease, disability, and death related to tobacco use.

You or Your – refers to the Member.

Section 2 Benefit Provisions

Coverage for Outpatient Prescription Drug Products

The Plan provides coverage for Prescription Drug Products, if all of these conditions are met:

1. You are an eligible Member in the Plan; and;
2. it is Medically Necessary;
3. the Prescription Drug Product is covered under the Plan and it is dispensed according to Plan guidelines;
4. it is obtained through a Network Retail, Mail order or Online Pharmacy or a Non Network Retail pharmacy;
5. Specialty Drugs for administration or injection must be obtained from the CVS/caremark Specialty Pharmacy;

Plan C - Prescription Drug Benefits

Coverage Level	Health Plan Annual Deductible	Health Plan Annual Out of Pocket Maximum Network
Single	**$2,750**	**$5,000**
Family	**$5,500**	**$10,000**

ALL Covered prescription drugs are subject to the combined medical and pharmacy Deductible of $2,750 for single & $5,500 for a family and then Coinsurance until the Out of Pocket Maximum is met.

Coverage Level	Prescription Drug Product	Coinsurance
Tier One	**Generic Drugs**	**20% Coinsurance**
Tier Two	**Preferred Drugs**	**40% Coinsurance**
Tier Three	**Non Preferred & Compound Medications**	**65% Coinsurance**
Tier Four	**Oral Cancer Medications**	**20% Coinsurance**

Out of Pocket Maximum
Once the combine medical and prescription drug Out of Pocket Maximum is met, additional eligible pharmacy claims will be reimbursed at 100% of the Allowable Charge for the remainder of the calendar year.

Benefits are provided for each eligible Prescription Drug Product filled, subject to payment of any applicable Deductible, Coinsurance or Copayment. The Provider and the patient, not the Plan or the employer determine the course of treatment. Whether or not the Plan will cover all or part of the treatment cost is secondary to the decision of what the treatment should be. If You use a Network Pharmacy, the Member's payment shall not exceed the Allowed Charge provided that You present Your identification card to the pharmacy as required. When a Non Network Pharmacy is used, You will be responsible

for the difference between the pharmacy's billed charge and Allowed Charge in addition to applicable Deductible. Benefits for services received from a Retail Non Network Pharmacy will be paid to the primary insured. To be eligible for coverage under the Plan, Specialty Pharmacy products that are self-administered or self injected must be purchased from the CVS/caremark Specialty Pharmacy. You cannot assign benefits under this program to any other person or entity. Non Covered Prescription Drug Products are not eligible for payment under the Plan unless Prior Authorization has been obtain and the prescription is considered to be Medically Necessity by the Plan. Information on the Performance Drug List, Preferred Drug List or Injectable List is available at:
http://www.caremark.com or **www.kdheks.gov/hcf/sehp**.

***Generic Prescription Drug Products*:**
All prescription Generic drugs are subject to the Health Plan Deductible. Once the Deductible is satisfied, Your Coinsurance is 20% of the Allowed Charge for eligible prescription drugs.

***Preferred Brand Name Prescription Drug Products**:*
All Preferred Brand Name Prescription Drugs are subject to the Health Plan Deductible. Once the Deductible is satisfied, Your Coinsurance is 40% of the Allowed Charge for eligible prescription drugs. The Preferred Drug List is subject to periodic review and modification.

Non Preferred Brand Name Drug Products:
For covered Non Preferred Brand Name Drug Products are subject to the Health Plan Deductible. Once the Deductible is satisfied, Your Coinsurance is 65% of the Allowed Charge for eligible prescription drugs.

Compound Medications:
Compound claims are only eligible for payment under this Plan when dispensed by a Network pharmacy. CVS/caremark Mail Order Pharmacy is a contracting compounding pharmacy. Eligible Compound Medications are subject to the Health Plan Deductible. Once the Deductible is satisfied, Your Coinsurance is 65% of the Allowed Charge for eligible prescription drugs.

Claims for Compound Medications submitted for reimbursement must contain more than one (1) Legend Drug ingredient. If Your Network pharmacy does not submit your claim, You will need to submit a paper claim for reimbursement. You will need to obtain the following information from the pharmacy to complete the claim form:

- List the **VALID 11 digit National Drug Code (NDC) number for EACH ingredient** used in the compound prescription.
- List the ingredient name for each NDC number.
- Indicate the "metric quantity" expressed in number of tablets, grams or milliliters for each ingredient NDC Number.
- Indicate the cost for EACH ingredient (dollar amount).
- Indicate the TOTAL compounded quantity.
- Indicate the TOTAL dollar amount paid by the patient.
- Compounds with a TOTAL cost of over $300 must be prior authorized. Failure to do so will result in the denial of the claim.

Please Note-If an ingredient cost is $0, a valid NDC number and quantity for the ingredient is still required. The total cost of all the ingredients in the compound must be less than the total dollar amount paid by the member for the compound.

ALL Compound Medications must be purchased at a Network pharmacy and if the TOTAL drug cost of the compound is over $300 the claim must be prior authorized by the Plan. Claims for Compound Medications over $300 that have not been prior authorized will be denied by the Plan.

The Plan reserves the right to review all compounded claims and exclude any excessive charges including but not limited to charges for bases and bulk compounding powders.

Exclusion of Select Topical Analgesics: Select topical analgesics will be excluded from coverage by the Plan. Compounded claims for pain patches or creams containing ingredients (alone or in combination) for the temporary relief of minor aches and muscle pains associated with arthritis, simple backache, strains, muscle soreness and stiffness are Non Covered services. Pain patches with ingredients including but not limited to: lidocaine, menthol, capsaicin and methyl salicylate are Non Covered services.

Contraceptive Medications for Women:
The Plan will pay 100% of the Allowed Charge for prescription contraceptive medications listed on the Preferred Drug List. If You and Your health care provider select a prescription contraceptive medication not listed on the Preferred Drug List, the claim will be subject to the Plan Deductible and the Non Preferred Drug Coinsurance.

The list of prescription contraceptive medications covered on the Preferred Drug List is subject to periodic review and modification. Female contraceptive products which are classified by the FDA as Over-The-Counter (OTC) and are included on the Preferred Drug List are eligible for coverage under this Plan if purchased with a prescription from Your Physician. This includes female contraceptive products that are FDA approved emergency contraceptives. To access coverage, You will need to present the prescription for the OTC item at the Network pharmacy and request that the claim be run through the CVS/caremark claim system or submit a paper claim with proper documentation of purchase and a copy of the prescription.

Discount Medications:
Discount Medications are Non Covered prescription medications under this Plan. If You purchase a medication designated by the Plan as a Discount Medication, You will be responsible for 100% of the Allowed Charge. The Allowed Charge is the CVS/caremark contracted reimbursement rate, and provides You with a discount off the retail price of these Non Covered medications. **Discount Medications do not count toward meeting Your Health Plan Deductible or Out of Pocket Maximum.**

Injectable Medications:
Coverage for Injectable drugs under this Plan is limited to those medications

that have been designated by the Plan Sponsor. A list of designated medications is available on the web at http://www.caremark.com or www.kdheks.gov/hcf/sehp. This list is subject to periodic review and modification. The Injectable treatment must be Medically Necessary and appropriate for the condition being treated. Some Injectable Medications are available through the Specialty Pharmacy program for home delivery. For those injectable items that require a medical professional to administer the drug, the cost for that injection is not covered under this Plan. These charges should be billed to Your medical insurance.

Oral Cancer Medications

Oral Cancer Medications are drugs that have been designated by the Plan as anti-cancer medication used to kill or slow the growth of cancerous cells. A complete list of eligible oral anti-cancer drugs are available at: **http://www.caremark.com** or **www.kdheks.gov/hcf/sehp**. Once the Deductible is satisfied, Your Coinsurance is 20% of the Allowed Charge for eligible prescription drugs. The Plan retains the final discretionary authority on what constitutes an oral anti-cancer prescription drug product. This list is subject to periodic review and modification.

Performance Drug List

The Preferred Drug List (PDL) provides You a number of Generic and Preferred Brand Name Drug options to lower cholesterol, reduce stomach acid and treat high blood pressure. We encourage You to take the PDL with You to Your medical appointments so that You can discuss Your prescription therapy options with Your physician. Using Generic drugs will save You and the Plan money.

Under the Performance Drug List, Generic and Preferred Brand Name drugs are available and considered a first line therapy. Non Preferred Brand Name Drugs for long-lasting reduction of gastric [stomach] acid production (PPIs - proton pump inhibitors) are only eligible for coverage by the Plan if You have a history of having tried at least one (1) Generic option. The CVS/caremark claim system will review Your claims history to determine whether or not You have a prior history of using a generic product in the same therapeutic class before a claim for a Non Preferred Brand Name Drug will be processed by the Plan.

Preventive Care

The following Preventive Care prescription and OTC items will be covered at 100% of the Allowed Charge by the Plan when purchased with a prescription from Your physician. For OTC items, You will need to present a physician's prescription to a Network pharmacy and have the claim run through the Caremark claim system or submit a paper claim with all proper documentation for reimbursement of the Allowed Amount. This list is not all inclusive and subject to periodic review and modification as federal guidelines for preventive care are updated:

- Adults age 65 and over: Vitamin D

- Adults age 45 and over: Aspirin
- Pregnant Women at high risk for pre-eclampsia: Aspirin
- Immunizations: Children and Adult
- Iron Supplements: Children under age 1
- Screening for Colorectal Cancer age 50 and over: Bowl Preparation Medications
- Women Breast Cancer Prevention age 35 and over
- Women under age 55 and over: Folic Acid
- Woman Preventive Services: See Women's Contraception Section of this document
- Children age 6 and under: Oral fluoride
- Tobacco Cessation Products: See Tobacco Control Section of this document

Specialty Drug

Specialty drugs are medications that have been designated by the Plan. To be eligible for coverage under the Plan, Specialty Drugs must be purchased from the CVS/caremark Specialty Pharmacy. The list of Specialty Drugs is available at www.caremark.com and is subject to periodic review and modification. All Specialty Drugs are subject to the Health Plan Deductible. Once the Deductible is satisfied, the Plans pays eligible prescription drugs purchased from the Caremark Specialty Pharmacy are subject to the appropriate Coinsurance tier. If You are participating in a Patient Assistance Program that provides payment in full or in part for Your Specialty Drug purchase, the amounts paid by the Patient Assistance Program will not count toward meeting the Plans Out Of Pocket requirements. Only Deductibles and Coinsurance that are actually paid by You will count toward meeting your Out Of Pocket Maximum.

For members requiring Specialty Drugs, CVS/caremark will enroll You in the Specialty Pharmacy program. The Specialty Pharmacy program focuses on patients who have complex and/or chronic conditions requiring expensive and/or complicated drug regimens that require close supervision and monitoring on an ongoing basis. Should You be prescribed a drug on the Specialty Drug List simply call CaremarkConnect at 1-800-237-2767. CVS/caremark will coordinate getting the prescription from the doctor, if necessary and work with You to set up delivery. As these products often require special handling, You can schedule drug delivery to Your home, office, doctor's office, local pharmacy or other location You designate. The medication along with any necessary supplies (at no additional cost) will typically be shipped overnight to You. You will not be charged any shipping charges. You will need to provide CVS/caremark with payment information for Your share of the drug cost.

You will be assigned a case manager who will be in contact with You on a regular basis to answer any question You may have regarding treatment, side effects and therapy compliance. These clinicians specialize in the management of chronic conditions. Individualized care plans are developed for patient-specific conditions and involve You, Your physician, nurse, case manager, and clinical pharmacist in a coordinated and monitored course of treatment. In addition, You will have access to pharmacist or nurses 24 hours a day, seven days a week should You have any question or concerns about

therapy. This program offers You a convenient source for these Specialty Drugs, lower potential drug–to-drug interactions and improved therapy compliance.

Comprehensive Site of Care Specialty Program

The Plan has identified certain Specialty Drugs for exclusive coverage under the Comprehensive Site of Care Specialty Program. CVS Specialty will work with You and Your provider on delivering these Specialty drug to You for self-administration or to Your provider for clinician administration or infusion. A complete list of prescription drugs included in the Comprehensive Site of Care Specialty Program is available on the Caremark website.

CVS Specialty may work with You and Your provider to provide Your treatment in an outpatient or home setting when appropriate. When CVS/caremark arranges the site of care for the administration of the prescription drug, claims must be submitted to Caremark for payment. All services are subject to the plan Deductible and then Coinsurance will apply. For the prescription drug itself will be subject to the standard pharmacy Coinsurance tiers. A twenty (20) percent Coinsurance will apply to the Allowed Amount for the administration or infusion of the medication.

Tobacco Control Wellness Program

The Plan will pay 100% of the Allowed Charge for tobacco control products listed on the Preferred Drug List. The Plan retains the final discretionary authority on what constitutes a tobacco control drug products. This list is subject to periodic review and modification. For covered OTC products, You will need to present Your physician's prescription order for the OTC item to a Network pharmacy and request that the claim be run through the Caremark claim system or submit a paper claim with proper documentation of purchase and a copy of the prescription.

Non Preferred Prescription drugs for tobacco control are covered by the Plan subject to the Plan Deductible and Coinsurance. Enrollment in an approved tobacco control program is recommended with use of these tobacco control prescription medications. The HealthQuest tobacco control program available to You at no cost is available on the State of Kansas Web site at: **www.KansasHealthQuest.com**.

Initial Prescription Drug Product Purchase

Covered Prescription Drug Products are subject to the initial fill limit of thirty-day (30) consecutive day supply or one standard unit of therapy whichever is less.

A standard unit of therapy is up to a thirty-day (30) consecutive day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size or "standard units of therapy guidelines." Some products may be subject to additional supply limits adopted by the Plan.

Refill Guidelines
Prescriptions may be filled through retail locations or Mail Order for up to a **ninety (90) day supply** if allowed by law or Plan guidelines. The refill prescriptions must be for the same strength of Prescription Drug Product.

- **For Non-Controlled Substance prescriptions**, the refill threshold is set at 75 percent. This means that 75 percent of a member's days supply must have lapsed before the prescription can be refilled.
- **For Controlled Substance prescriptions,** the refill threshold is set at 80 percent. This means that 80 percent of a member's days supply must have lapsed before the prescription can be refilled.

Advance Purchases

Advance Purchase of maintenance Prescription Drug Products are available for active employees only who will be departing the U.S. for an extended period of time. The applicable Plan Deductible, and Coinsurance are required for each thirty (30) day supply or standard unit of therapy received. Purchases must be made at a Network Pharmacy other than the CVS/caremark Mail Service Pharmacy. Active employees may contact their Human Resource office to obtain the Advance Purchase Certificate. The completed form must be signed by both the You and an agency employee with the authority to expend agency funds, and submitted to the State Employee Health Plan office **15 days in advance** of the anticipated departure date. Up to a one (1) year supply of medications may be obtained if the request is approved. If drugs cross the plan year, the Plan deductible and Coinsurance will apply.

When adequate time is not available to submit an Advance Purchase Request or purchases are made outside of the country You may submit the pharmacy receipts for reimbursement upon return from the extended absence. In order to be considered for reimbursement, the patient must have continuous coverage for the entire period of absence. The Plan will reimburse You based upon the Allowed Charge for the service. You will be responsible for the difference between the pharmacy's billed charged and Allowed Charge in addition to applicable Deductible and Out of Pocket Maximum.

For Prescription drug Products purchased in the United States by the Member in excess of the supply limits of the Plan may be covered once the time period covered by the excess supply has elapsed so long as the excess supply purchased does not overlap any other purchases for the same product. Claims must be filed within one (1) year and ninety (90) days of the date of purchase to State Employee Health Plan, 900 SW Jackson, Rm. 900-N, Topeka, KS 66612.

Prescription Drug Products purchased and used while outside the United States must include documentation of the purchase to include the original receipt that contains the patient's name, the name of the Prescription Drug Product, day supply and quantity purchased and price paid. An English translation and currency exchange rate for the date of service is required from You in order to process the claim. Only Prescription Drug Products that are eligible for payment under this Plan may be claimed for reimbursement. Claims must be filed within one (1) year and ninety (90) days of the date of

of purchase to State Employee Health Plan, 900 SW Jackson, Rm. 900-N, Topeka, Ks 66612.

Home Delivery Pharmacy
CVS/caremark offers a home delivery service that may save You money on Your prescription drug services. The Home Delivery Pharmacy is a convenient and cost effective way to obtain Your medication through the mail to any location in the United States. **Home Delivery is limited to a ninety (90) day supply and may be dispensed with member paying the applicable Deductible and Coinsurance.** All supply limits and Plan requirements apply to home delivery pharmacy purchases.

If You have an ongoing prescription and wish to start home delivery, CVS/caremark will work with You and Your physician to get you enrolled in home delivery. Simply call FastStart® toll free at **(866) 772-9503**. You must have Your prescription information as well as Your physician's telephone and FAX numbers available for the representative. CVS/caremark will call Your physician directly for Your prescription information and enroll You for mail service as soon as Your physician provides the necessary information. You will need to provide CVS/caremark with payment information for Your share of the drug cost.

If You have paper prescription, to begin home delivery, send the original prescription along with the Mail Order Service Profile form (available at **http://www.caremark.com** or **www.kdheks.gov/hcf/sehp** or by calling **1-800-294-6324)** to CVS/caremark. You will need to include Your payment information for Your share of the drug cost.

New prescriptions and refills will typically arrive directly at Your home within 7-10 business days from the day You mail Your order. The mail order pharmacy is required by law to dispense the prescription in the exact quantity specified by the physician. Therefore, if the quantity prescribed is for less than Plan maximums per fill, the mail order pharmacy will fill the exact quantity prescribed.

For refills:
The prescription label lists the date when You can request a refill and shows how many refills You have left. Refill prescriptions on the Internet by visiting **http://www.caremark.com**. Have Your prescription number, date of birth and credit card information ready. You can also order refills by phone or through the mail. To use the automated phone service, call the toll-free number on the prescription label and have the prescription number, ZIP code and credit card information ready. Or, mail the refill slip and payment to **CVS/caremark** in the envelope that was included with Your previous shipment.

Paper Claims
Members will need to file a paper claim for the following situations:

- **Anytime covered Prescription Drug Products are purchased from a Non Network Pharmacy.**
- If You do not present Your Identification Card at a Network Pharmacy and are charged the retail cost of the Prescription, You will be responsible for filing a paper claim for reimbursement.

(The CVS/caremark Help Desk **1-800-364-6331** can assist in transmitting a claim on-line if the Member does not have their Identification Card available.)

- If a Prescription Drug Product requires prior authorization and it has not been obtained, the Member may pay the full purchase price for the Product and submit a claim along with documentation for consideration of coverage under the Plan. Payment is not guaranteed by the Plan.

In any of these situations, You must pay full retail price at the pharmacy. A claim form should then be completed and sent (along with the original receipt and any additional information) to: **CVS/caremark / P.O. Box 52136/Phoenix, AZ 85072-2136**. Reimbursement to the Member for the cost of the prescription is limited to the Allowed Charge a Network Pharmacy would have been paid, less applicable Deductible and/or Coinsurance. Claim forms can be found on the internet at http://www.caremark.com.

Time Limit for Filing Claims

You are responsible for making sure the Network Pharmacy knows You have prescription drug coverage and submits a claim for You. Most claims under this program are submitted electronically at the time of purchase. For those claims that are not, electronic claims may be submitted or adjusted within thirty (30) days of purchase. If You use a Non Network Provider, You must submit the notice yourself. Notice of Your claim must be given to the Plan within ninety (90) days after You receive services. If it is not reasonably possible for You to submit a claim within ninety (90) days after You receive services, You or someone authorized by You must submit the claim as soon as reasonably possible. No claim will be paid if not received by the Company within one (1) year and ninety (90) days after You receive services.

Section 3 *Coordination of Benefits*

Coordination of Benefits with Commercial Insurance

Only prescription drug products covered under this Plan are eligible for payment. The Allowed Charge will be the amount allowed but not covered by the other plan. Payments are subject to this Plan's applicable Deductible, Copayments and Plan provisions and limitations.

Order of Benefit Determination

If You are covered under more than one group plan providing drug coverage, the plan that covers You as an active employee is primary to the plan that covers You as a dependent (spouse or child) or retired employee, unless otherwise required by Medicare.

Determination of primary/secondary coverage for dependent children will be based upon the "birthday rule" unless otherwise required by court order or by law. The primary plan is the plan of the parent whose birthday is earlier (month and day) in the year.

If the parents are not married or separated (whether or not they were married) or are divorced, and the court decree does not allocate responsibility for health care or expenses, the order of benefit determination will be as

follows:

a) The plan of the custodial parent;
b) The plan of the spouse of the custodial parent;
c) The plan of the noncustodial parent, and then
d) The plan of the spouse of the noncustodial parent.

Section 4 Other Plan Provisions

Fraudulent, Inappropriate Use or Misrepresentation

You and Your dependent(s) coverage may be terminated and other appropriate action taken as determined by the Plan Sponsor, if You or Your dependents participate in any act that constitutes fraud, gross misbehavior, misrepresentation or omission of pertinent facts in applying for or seeking benefits under the Plan. This shall also include other improper action as determined by the Plan Sponsor. This includes but is not limited to:

a. Misrepresent or omission of material facts to obtain coverage or allowing unauthorized persons use of Your State of Kansas Drug Plan identification card to obtain services, supplies or medication that are not prescribed or ordered for You or a covered family member or for which You are not otherwise entitled to receive. In this instance, Coverage for You and/or any covered dependent(s) may be terminated by the Plan Sponsor and any other action determined appropriate by the Plan Sponsor.

b. Permitting the unauthorized use of Your State of Kansas Drug Plan identification card to obtain medication, services or supplies for someone not covered under Your State of Kansas Prescription Drug membership. In this instance, Coverage of the member and/or dependent(s) may be terminated by the Plan Sponsor and any other action determined appropriate by the Plan Sponsor.

c. Using another State of Kansas member's Prescription Drug Plan identification card to obtain medication, services or supplies for Your or some other third party not specifically covered under that membership may result in the termination of Your coverage and that of Your dependents by the Plan Sponsor and any other action determined appropriate by the Plan Sponsor.

Appeal and External Review

Definitions

The following terms are used herein to describe the claims and appeals reviewservices provided by CVS/caremark:

Adverse Benefit Determination – A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a covered Plan benefit. An adverse benefit determination includes a denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for, a covered Plan benefit based on the application of a utilization review or on a determination of a Plan Member's eligibility to participate in the Plan. An adverse benefit determination also includes a failure to cover a Plan benefit

because use of the benefit is determined to be experimental, investigative, or not medically necessary or appropriate. The Plan's determination of a drug's particular coverage tier is not an Adverse Benefit Determination eligible for appeal or external review. For example, the Plan's designation of a drug a "Discount Medication" (Tier 5) is not considered an Adverse Benefit Determination and therefore is not eligible for appeal or external review.

Claim – A request for a Plan benefit that is made in accordance with the Plan's established procedures for filing benefit claims.

Medically Necessary (Medical Necessity) – Medications, health care services or products are considered Medically Necessary if:

- Use of the medication, service, or product is accepted by the health care profession in the United States as appropriate and effective for the condition being treated;
- Use of the medication, service, or product is based on recognized standards for the health care specialty involved;
- Use of the medication, service, or product represents the most appropriate level of care for the Member, based on the seriousness of the condition being treated, the frequency and duration of services, and the place where services are performed; and
- Use of medication, service or product is not solely for the convenience of the Member, Member's family, or provider.

Non Covered Services – claims denied because the prescription drug product, item or service are not a covered service under the Plan may not be appealed for external review. This would include prescription drug products included in the Discount Tier.

Post-Service Claim – A Claim for a Plan benefit that is not a Pre-Service or Urgent Care Claim.

Pre-authorization – CVS/caremark pre-service review of a Member's initial request for a particular medication. CVS/caremark will apply a set of pre-defined criteria (provided by the Plan Sponsor) to determine whether there is need for the requested medication.

Pre-Service Claim – A Claim for a medication, service, or product that is conditioned, in whole or in part, on the approval of the benefit in advance of obtaining the requested medical care or service. Pre-Service Claims include Member requests for pre-authorization.

Urgent Care Claim – A Claim for a medication, service, or product where a delay in processing the Claim: (i) could seriously jeopardize the life or health of the Member, and/or could result in the Member's failure to regain maximum function, or (ii) in the opinion of a physician with knowledge of the Member's condition, would subject the Member to severe pain that cannot be adequately managed without the requested medication, service, or product. CVS/caremark will defer to the Member's attending health care provider as to whether or not the Member's Claim constitutes an Urgent Care Claim.

Claims and Appeals Process

Pre-authorization Review:

CVS/caremark will implement the prescription drug cost containment programs requested by the Plan Sponsor by comparing Member requests for certain medicines and/or other prescription benefits against pre-defined preferred drug lists or formularies before those prescriptions are filled.

If CVS/caremark determines that the Member's request for pre-authorization cannot be approved, that determination will constitute an Adverse Benefit Determination.

Appeals of Adverse Benefit Determinations:

If an Adverse Benefit Determination is rendered on the Member's Claim, the Member may file an appeal of that determination. The Member's appeal of the Adverse Benefit Determination must be made in writing and submitted to CVS/caremark within 180 days after the Member receives notice of the Adverse Benefit Determination. If the Adverse Benefit Determination is rendered with respect to an Urgent Care Claim, the Member and/or the Member's attending physician may submit an appeal by calling CVS/caremark. The Member's appeal should include the following information:

- Name of the person the appeal is being filed for;
- CVS/caremark Identification Number
- Date of birth;
- Written statement of the issue(s) being appealed;
- Drug name(s) being requested; and
- Written comments, documents, records or other information relating to the Claim.

The Member's appeal and supporting documentation may be mailed or faxed to CVS/caremark:

CVS/caremark
Appeals Department
MC 109
P.O. Box 52084
Phoenix, AZ 85072-2084
Fax Number: 1-866-689-3092

Physicians may submit urgent appeal requests by calling the physician-only toll-free number: 1-866-443-1183

CVS/caremark Review:

The review of a Member's Claim or appeal of an Adverse Benefit Determination will be conducted in accordance with the requirements of any State and Federal laws . Members will be accorded all rights granted to them under relevant laws. CVS/caremark will provide the first-level review of appeals of Pre-Service Claims. If the Member disagrees with CVS/caremark's decision, the Member can request an additional second-level Medical

Necessity review. That review will be conducted by an Independent Review Organization ("IRO").

Timing of Review:
Pre-Authorization Review – CVS/caremark will make a decision on a Pre-Authorization request for a Plan benefit within 15 days after it receives the request. If the request relates to an Urgent Care Claim, CVS/caremark will make a decision on the Claim within 72 hours.

Pre-Service Claim Appeal – CVS/caremark will make a decision on a first-level appeal of an Adverse Benefit Determination rendered on a Pre-Service Claim within 15 days after it receives the Member's appeal. If CVS/caremark renders an Adverse Benefit Determination on the first-level appeal of the Pre-Service Claim, the Member may appeal that decision by providing the information described above. A decision on the Member's second-level appeal of the Adverse Benefit Determination will be made (by the IRO) within 15 days after the new appeal is received. If the Member is appealing an Adverse Benefit Determination of an Urgent Care Claim, a decision on such appeal will be made not more than 72 hours after the request for appeal(s) is received.

Post-Service Claim Appeal – CVS/caremark will make a decision on an appeal of an Adverse Benefit Determination rendered on a Post-Service Claim within 60 days after it receives the appeal.

Scope of Review:
During its pre-authorization review, first-level review of the appeal of a Pre-Service Claim, or review of a Post-Service Claim, CVS/caremark shall:

- Take into account all comments, documents, records and other information submitted by the Member relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination on the Claim;
- Follow reasonable procedures to verify that its benefit determination Is made in accordance with the applicable Plan documents;
- Follow reasonable procedures to ensure that the applicable Plan provisions are applied to the Member in a manner consistent with howsuch provisions have been applied to other similarly-situated Members; and
- Provide a review that does not afford deference to the initial Adverse Benefit Determination and is conducted by an individual other than the individual who made the initial Adverse Benefit Determination (or a subordinate of such individual).

If a Member appeals CVS/caremark's denial of a Pre-Service Claim, and requests an additional second-level Medical Necessity review by an IRO, the IRO shall:

- Consult with an appropriate health care professionals who was not consulted in connection with the initial Adverse Benefit Determination (nor a subordinate of such individual);
- Identify the health care professional, if any, whose advice was obtained on behalf of the Plan in connection with the Adverse Benefit Determination; and
- Provide for an expedited review process for Urgent Care Claims.

Notice of Adverse Benefit Determination:
Following the review of a Member's Claim, CVS/caremark will notify the Member of any Adverse Benefit Determination in writing. (Decisions on Urgent Care Claims will be communicated by telephone or fax.) This notice will include:

- The specific reason or reasons for the Adverse Benefit Determination; Reference to pertinent Plan provision on which the Adverse Benefit Determination was based;
- A statement that the Member is entitled to receive, upon written request, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claim;
- If an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, either a copy of the specific rule, guideline, protocol or other similar criterion; or a statement that such rule, guideline, protocol or other similar criterion will be provided free of charge upon written request; and
- If the Adverse Benefit Determination is based on a Medical Necessity, either the IRO's explanation of the scientific or clinical judgment for the IRO's determination, applying the terms of the Plan to the Member's medical circumstances, or a statement that such explanation will be provided free of charge upon written request.

Authority as Claims Fiduciary:
CVS/caremark shall serve as the claims fiduciary with respect to pre-authorization review of prescription drug benefit Claims arising under the Plan, first-level review of appeals of Pre-Services Claims, and review of Post-Service Claims. CVS/caremark shall have, on behalf of the Plan, sole and complete discretionary authority to determine these Claims conclusively for all parties. CVS/caremark is not responsible for the conduct of any second-level Medical Necessity review performed by an IRO. Likewise, CVS/caremark is not responsible for the conduct of any State External Review conducted by an External Review Organization (discussed below.)

Procedure For Pursuing An External Review
The Covered Member has the right to request an External Review when the reason for the final second appeal and notice of an Adverse Benefit Decision was that the prescription drug was not medically necessary or was experimental or investigational. CVS/caremark will notify the Covered Member in writing regarding a final Adverse Benefit Decision and of the opportunity to request an External Review.

Within 90 days of receipt of the notice of the second appeal and notice of the Adverse Benefit Decision, the Covered Member, the treating Physician or

health care provider acting on behalf of the Covered Member with written authorization from the Covered Member, or a legally authorized designee of the Covered Member must make a written request for an External Review to the State Employee Health Plan, 900 SW Jackson, Rm. 900 N, Topeka, Kansas 66612. The State Employee Health Plan will work with the Kansas Insurance Department to obtain an external review.

Within 10 business days of receipt of such request (immediately, when the request for External Review involves an Emergency Medical Condition), the Kansas Insurance Department will notify the Covered Member and other involved parties as to whether the request for External Review is granted.

For those requests that qualify for External Review, the External Review Organization will issue a written decision to the Covered Member and the Kansas Insurance Department within 30 days. The External Review Organization will issue its written decision within 7 business days when the request for External Review involves an Emergency Medical Condition. If any party is not satisfied with the decision of the External Review organization, they may pursue normal remedies of law.

The right to External Review shall not be construed to change the terms of coverage under this Benefit Description. A Covered Member may not pursue, either concurrently or sequentially, an External Review under both state and federal law. The Covered Member shall have the option of designating which External Review process will be utilized.

Exclusions

The Plan does not cover the following:

1. Prescription Drug Products in amounts exceeding the supply limit referenced in Section 2.
2. Drugs which are prescribed, dispensed, or intended for use while You are an inpatient in a hospital or other facility.
3. Experimental, Investigational, Educational or Unproven Services, technologies which include medical, surgical, diagnostic, psychiatric, substance abuse, or other health care, supplies, treatments, procedures, drug therapies or devices.
4. Prescription Drug Products furnished to a Member by any local, state or federal government entity; except as otherwise provided by law, any Prescription Drug Product to the extent payment or benefits are provided or available from any local, state or federal government entity (for example, Medicare) regardless of whether payment or benefits are received.
5. Prescription Drug Products for any condition, illness, injury, sickness or mental illness arising out of or in the course of employment for which compensation benefits are available under any Worker's Compensation Law or other similar laws, regardless of whether the Member makes a claim for, or receives such compensation or benefits.
6. Compounded drugs not containing at least one (1) ingredient with a valid National Drug Code (NDC) number and requiring a Physician's Order to

dispense. In addition, the Compounded Medication must have FDA approval.

7. Compounded claims for pain patches or creams containing ingredients (alone or in combination) for the temporary relief of minor aches and muscle pains associated with arthritis, simple backache, strains, muscle soreness and stiffness. Pain patches with ingredients including but not limited to: lidocaine, menthol, capsaicin and methyl salicylate are Non Covered services.
8. Compound drugs purchased from a Non Network pharmacy.
9. Drugs available over-the-counter or for which the active ingredients do not require a Prescription by federal or state law unless otherwise stated as eligible for coverage under in this benefit description.
10. Injectable drugs administered by a Health Professional in an inpatient or outpatient setting.
11. Durable or disposable medical equipment or supplies, other than the specified diabetic and ostomy supplies.
12. Replacement Prescription Drug Products resulting from damaged, lost, stolen or spilled Prescription Orders or Refills.
13. Legend general vitamins except Legend prenatal vitamins, Legend vitamins with fluoride, and Legend single entity vitamins.
14. Prescription Drug Products that are not medically necessary.
15. Charges to administer or inject any drug.
16. Prescription Drug Products that are administered or entirely used up at the time and place ordered, such as in a clinic or physician's office.
17. Prescription Drug Products for which there is normally no charge in professional practice.
18. Therapeutic devices, artificial appliances, or similar devices, regardless of intended use.
19. Prescription Drug Products purchased from an institutional pharmacy for use while the Member is an inpatient in that institution.
20. Charges for the delivery of any drugs.
21. Prescription Drug Products approved for experimental use only.
22. The Plan has the right to deny benefits for any drug prescribed or dispensed in a manner that does not agree with normal medical or pharmaceutical practice.
23. Benefits are not available to the extent a Prescription Drug Product has been covered under another contract, certificate or rider issued by the Plan Sponsor.
24. Coverage for allergy antigens under any circumstances.
25. Enteral nutritional supplements which do not qualify as a Prescription Drug Product as defined herein.
26. Drugs imported for use in the United States from foreign countries.
27. Drugs imported for use in the United States from foreign countries.

Section 5 Prior Authorization

Certain Prescription Drug Products require Prior Authorization to be covered by the Plan. Prior Authorization is usually initiated by Your physician or other authorized representative on Your behalf, however it remains Your responsibility. If these Prescription Drug Products are not authorized before being dispensed, You will be responsible for paying the full retail charge. In this case, You will need to submit a paper claim with supporting documentation to allow for consideration under the Plan. The Plan retains the final discretionary authority regarding coverage by the Plan.

The following list of medications require Prior Authorization to be covered. This list is subject to periodic review and modifications:

** Drugs highlighted in bold italic type are Specialty Drugs that require prior authorization review. Please have Your physician call 1-866-814-5506.*

***ACROMEGALY**
octreotide (SANDOSTATIN)
Mircera
Sandostatin LAR Depot
Signifor LAR
Somatuline Depot
Somavert

ADHD/NARCOLEPSY
Adderall
Adderall XR
Adzenys XR-ODT
Desoxyn
Dextroamphetamine Products
Dexedrine
Dyanavel XR
Evekeo
ProCentra
Vyvanse

***ALCOHOL AND OPIOID DEPENDENCY**
Vivitrol

***ALLERGIC ASTHMA**
Nucala
Xolair

***ALPHA1-ANTITRYPSIN (AAT) DEFICIENCY**
Aralast NP
Glassia
Prolastin-C
Zemaira

***ANEMIA**
Aranesp
Epogen
Mircera

***BONE DISORDERS**
Strensiq

***BOTULINUM TOXINS**
Botox
Dysport
Myobloc
Xeomin

***CARDIAC DISORDERS**
Tikosyn

***CENTRAL PRECOCIOUS PUBERTY (CPP)**
leuprolide
Lupron Depot-PED
Supprelin LA

***COAGULATION DISORDERS**
Ceprotin
***CRYOPYRIN-ASSOCIATED PERIODIC SYNDROMES (CAPS)**
Arcalyst
Ilaris

***CUSHING'S SYNDROME**
Korlym
Signifor

***CYSTIC FIBROSIS (CF)**
Bethkis
Cayston
Kalydeco
Kitabis Pak
Orkambi
Pulmozyme
tobramycin inhalation solution

DIABETIC
Symlin
Trulicity
Victoza

***ELECTROLYTE DISORDERS**
Samsca

***GASTROINTESTINAL DISORDERS – OTHER**
Cholbam
Gattex
Zorbtive

***GOUT**
Krystexxa

***GROWTH HORMONE (GH) AND RELATED DISORDERS**
Humatrope
Increlex

HEART FAILURE
Entresto

***HEMATOPOIETICS**
Mozobil
Neumega

***HEMOPHILIA AND RELATED *BLEEDING DISORDERS**
Advate
Adynovate
Alphanate
AlphaNine SD
Alprolix
Bebulin VH
BeneFIX
Coagadex
Corifact
Eloctate
Feiba NF
Feiba VH
Helixate FS
Hemofil M
Humate-P
Ixinity
Koate-DVI

Kogenate FS
Monoclate-P
Mononine
Novoeight
NovoSeven
Nuwiq
Obizur
Profilnine SD
Recombinate
RiaSTAP
Rixubis
Stimate Nasal Spray
Tretten
Wilate
Xyntha

***HEPATITIS C**
Daklinza
Harvoni
Incivek
Olysio
Peg-Intron
ribavirin
capsules/tablets
Sovaldi
Technivie
Victrelis

***HEREDITARY ANGIOEDEMA (HAE)**
Berinert
Cinryze
Firazyr
Kalbitor
Ruconest

***HORMONAL THERAPIES**
Aveed
Eligard
Firmagon
leuprolide
Lupaneta Pack
Lupron Depot
Natpara
Trelstar
Vantas
Zoladex

***HUMAN IMMUNODEFICIENCY VIRUS (HIV)**
Egrifta
Fuzeon
Serostim

***IMMUNE THERAPIES**
Bivigam
Carimune NF
Cytogam
Flebogamma
GamaSTAN S/D
Gammagard
Gammaked
Gammaplex
Gamunex
Hizentra
HyQvia
Octagam
Privigen

***IMMUNE (IDIOPATHIC) THROMBOCYTOPENIA (ITP)**
Nplate
Promacta

***INFECTIOUS DISEASE**
Actimmune
Alferon-N

***INFLAMMATORY BOWEL DISEASE (IBD)**
Entyvio
Humira
Tysabri

***IRON OVERLOAD**
deferoxamine
(DESFERAL)
Exjade
Ferriprox
Jadenu

***LIPID DISORDERS**
Juxtapid
Kynamro
Repatha

***LIPODYSTROPHY**
Myalept

***LYSOSOMAL STORAGE DISORDERS (LSD) AND RELATED DISORDERS**
Adagen
Aldurazyme
Cerdelga
Cerezyme
Cystagon
Cystaran
Elaprase
Elelyso
Fabrazyme
Kanuma
Lumizyme
Myozyme
Naglazyme
Orfadin
Procysbi
Vimizim
VPRIV
Zavesca

MIGRAINE
Alsuma
Amerge
Axert
Frova
Imitrex Nasal Spray
Imitrex Tablet
Imitrex Injection
Maxalt/MLT
Onzetra Xsail
Relpax
Sumavel
Treximet
**Zecuity*
Zembrace
SymTouch
Zomig/ZMT
Zomig Nasal Spray

***MOVEMENT DISORDERS**
Apokyn
Northera
tetrabenazine

***MULTIPLE SCLEROSIS (MS)**
Ampyra
Aubagio
Betaseron
Copaxone
Gilenya
Glatopa
Lemtrada
mitoxantrone
Rebif
Tecfidera
Tysabri

***NEUTROPENIA**
Granix
Leukine
Neulasta
Neupogen
Zarxio

***ONCOLOGY**
Adcetris
Afinitor
Alecensa
Arzerra
Avastin
azacitidine (Vidaza)
Beleodaq
Bendeka
Blincyto
Bosulif
capecitabine (Xeloda)
Caprelsa
Cometriq
Cotellic
Cyramza
Darzalex
decitabine (Dacogen)
Empliciti
Erbitux
Erivedge
Erwinaze
Farydak
Folotyn
Fusilev
Gazyva
Gilotrif
Gleevec
Halaven
Herceptin
Hycamtin Capsules
Ibrance
Iclusig
Imatinib mesylate
Imbruvica
Imlygic
Inlyta
Intron-A
Iressa
Istodax
Ixempra
Jakafi
Jevtana
Kadcyla
Keytruda
Kyprolis
Lenvima
Lonsurf
Lynparza
Mekinist
mitoxantrone
Nexavar
Ninlaro
Odomzo
Oncaspar
Opdivo
Perjeta
Pomalyst
Portrazza
Proleukin
Revlimid
Rituxan
Sprycel
Stivarga
Sutent
Sylatron
Sylvant
Synribo
Tafinlar
Tagrisso
Tarceva
Targretin
temozolomide (Temodar)
Thalomid
Torisel
Treanda
Tykerb
Unituxin
Valchlor
Valstar
Vectibix
Velcade
Votrient
Xalkori
Xgeva
Yervoy
Zaltrap
Zelboraf
zoledronic acid (Zometa)
Zolinza
Zydelig
Zykadia
Zytiga

***OSTEOARTHRITIS (OA)**
Gel-One
Hyalgan
Supartz

***OSTEOPOROSIS**
Forteo
zoledronic acid (Reclast)

***PAIN MANAGEMENT**
Prialt

***PAROXYSMAL NOCTURNAL HEMOGLOBINURIA (PNH)**
Soliris

***PHENYLKETONURIA (PKU)**
Kuvan

***PRE-TERM BIRTH**
Makena

***PSORIASIS**
Cosentyx
Enbrel
Humira
Otrexup
Rasuvo

***PULMONARY ARTERIAL HYPERTENSION (PAH)**
Adempas
epoprostenol (Flolan)
Letairis
Orenitram
Remodulin
sildenafil
Tracleer
Tyvaso
Veletri
Ventavis

***PULMONARY DISORDERS – OTHER**
Esbriet
Ofev

***RENAL DISORDERS**
Sensipar

***RESPIRATORY SYNCYTIAL VIRUS**
Synagis

***RETINAL DISORDERS**
Avastin
Eylea
Lucentis
Macugen
Visudyne

***RHEUMATOID ARTHRITIS (RA)**
Enbrel
Humira
Otrexup
Rasuvo
Rituxan

***SEIZURE DISORDERS**
Acthar
Sabril

***SLEEP DISORDERS**
Hetlioz

***SYSTEMIC LUPUS ERYTHEMATOSUS**
Benlysta

TRETINOIN PRODUCTS
Atralin
Avita
Retin-A
Retin-A Micro
Tretin-X
Tretinoin
Veltin
Ziana

***UREA CYCLE DISORDERS**
Buphenyl
Carbaglu
Ravicti

Kansas State Employee Health Plan
Preferred Drug List

2016

Effective 01/01/2016

For questions or additional information, access the State of Kansas website at **http://www.kdheks.gov/hcf/sehp** or call the **Kansas State Employees Prescription Drug Program** toll-free at **1-800-294-6324**.

The Preferred Drug List is subject to change. To locate covered prescriptions online, access the State of Kansas website at **http://www.kdheks.gov/hcf/sehp** for the most current drug list.

What is a Preferred Drug List?

A Preferred Drug List is a list of safe and cost-effective drugs, chosen by a committee of physicians and pharmacists. Drug lists have been used in hospitals for many years to help ensure quality drug use. The Kansas State Employees Preferred Drug List will be continually revised to reflect the changing drug market.

Should I ask my physician to switch my current medications to a medication that is on the Preferred Drug List?

Many of your medications will already be on the Preferred Drug List. However, if you have a medication that is not, ask your physician to choose a similar Preferred Drug List product for you to use.

Should I use generics?

There are many medications on the market that do not come in generic form. For those drugs that do, your pharmacist should suggest safe and effective generic alternatives.

This document is subject to state-specific regulations and rules, including, but not limited to, those regarding generic substitution, controlled substance schedules, preference for brands and mandatory generics whenever applicable.

Boldface type indicates generic availability; boldface may not apply to every strength or dosage form under the listed generic name.

Your Kansas State Employees Preferred Drug List As Of January 2016

ANALGESICS

NSAIDs
diclofenac sodium delayed-rel
diflunisal
etodolac
ibuprofen
meloxicam
nabumetone
naproxen
naproxen sodium
oxaprozin
sulindac

NSAIDs, COMBINATIONS
diclofenac sodium delayed-rel/misoprostol

NSAIDs, TOPICAL
diclofenac sodium soln
diclofenac sodium gel (VOLTAREN GEL)

COX-2 INHIBITORS
celecoxib

GOUT
allopurinol
colchicine (COLCRYS)
probenecid
febuxostat (ULORIC)

OPIOID ANALGESICS
codeine/acetaminophen
fentanyl transdermal
fentanyl transmucosal lozenge
hydrocodone/acetaminophen
hydromorphone
hydromorphone ext-rel
methadone
morphine
morphine ext-rel
morphine supp
oxycodone caps, tabs 5 mg
oxycodone concentrate 20 mg/mL
oxycodone tabs 15 mg, 30 mg, soln 5 mg/5 mL
oxycodone/acetaminophen 5/325
tramadol
tramadol ext-rel
buprenorphine transdermal (BUTRANS)
fentanyl citrate buccal (FENTORA)
fentanyl sublingual spray (SUBSYS)
fentanyl sublingual tabs (ABSTRAL)
oxycodone ext-rel (OXYCONTIN)
oxymorphone ext-rel (OPANA ER)
tapentadol (NUCYNTA)
tapentadol ext-rel (NUCYNTA ER)

NON-OPIOID ANALGESICS
butalbital/acetaminophen/caffeine tabs
butalbital/aspirin/caffeine

ANTI-INFECTIVES

ANTIBACTERIALS

Cephalosporins

First Generation
cefadroxil
cephalexin

Second Generation
cefprozil
cefuroxime axetil

Third Generation
cefdinir
cefixime (SUPRAX)

Erythromycins/Macrolides
azithromycin
clarithromycin
clarithromycin ext-rel
erythromycin delayed-rel
erythromycin ethylsuccinate
erythromycin stearate
erythromycin/sulfisoxazole
fidaxomicin (DIFICID)

Fluoroquinolones
ciprofloxacin
ciprofloxacin ext-rel
levofloxacin
moxifloxacin

Penicillins
amoxicillin
amoxicillin/clavulanate
amoxicillin/clavulanate ext-rel
ampicillin
dicloxacillin
penicillin VK

Tetracyclines
doxycycline hyclate
minocycline
tetracycline

ANTIFUNGALS
clotrimazole troches
fluconazole
griseofulvin ultramicrosize
itraconazole
nystatin
terbinafine tabs
voriconazole

ANTIMALARIALS
atovaquone/proguanil
chloroquine
mefloquine
artemether/lumefantrine (COARTEM)

ANTITUBERCULAR AGENTS
ethambutol
isoniazid

Boldface type indicates generic availability.

pyrazinamide
rifampin

ANTIVIRALS

Cytomegalovirus Agents
valganciclovir

Herpes Agents
acyclovir caps, tabs
famciclovir
valacyclovir

Influenza Agents
oseltamivir (TAMIFLU)
zanamivir (RELENZA)

MISCELLANEOUS
clindamycin
dapsone
ivermectin
metronidazole
nitrofurantoin ext-rel
nitrofurantoin macrocrystals
nitrofurantoin susp
sulfamethoxazole/trimethoprim
sulfamethoxazole/trimethoprim DS
tinidazole
trimethoprim
vancomycin
albendazole (ALBENZA)
rifaximin (XIFAXAN 550 mg)
tedizolid (SIVEXTRO)

ANTINEOPLASTIC AGENTS

ALKYLATING AGENTS
lomustine (CEENU)
altretamine (HEXALEN)
busulfan (MYLERAN)
chlorambucil (LEUKERAN)
cyclophosphamide caps
(CYCLOPHOSPHAMIDE caps)
melphalan (ALKERAN)

ANTIMETABOLITES
mercaptopurine
methotrexate (TREXALL)
thioguanine (TABLOID)

HORMONAL ANTINEOPLASTIC AGENTS

Antiandrogens
bicalutamide
flutamide

Antiestrogens
tamoxifen

Aromatase Inhibitors
anastrozole
exemestane
letrozole

Progestins
megestrol acetate

MISCELLANEOUS
etoposide
hydroxyurea
tretinoin caps
mitotane (LYSODREN)
procarbazine (MATULANE)

CARDIOVASCULAR

ACE INHIBITORS
benazepril
captopril
enalapril
fosinopril
lisinopril
perindopril
quinapril
ramipril
trandolapril

ACE INHIBITOR/CALCIUM CHANNEL BLOCKER COMBINATIONS
amlodipine/benazepril
trandolapril/verapamil ext-rel (TARKA)

ACE INHIBITOR/DIURETIC COMBINATIONS
benazepril/hydrochlorothiazide
captopril/hydrochlorothiazide
enalapril/hydrochlorothiazide
fosinopril/hydrochlorothiazide
lisinopril/hydrochlorothiazide
quinapril/hydrochlorothiazide

ADRENOLYTICS, CENTRAL
clonidine
clonidine transdermal
guanfacine

ALDOSTERONE RECEPTOR ANTAGONISTS
eplerenone
spironolactone

ALPHA BLOCKERS
doxazosin
terazosin

ANGIOTENSIN II RECEPTOR ANTAGONISTS/DIURETIC COMBINATIONS
candesartan
candesartan/hydrochlorothiazide
eprosartan
irbesartan
irbesartan/hydrochlorothiazide
losartan
losartan/hydrochlorothiazide
telmisartan
telmisartan/hydrochlorothiazide
valsartan
valsartan/hydrochlorothiazide

olmesartan (BENICAR)
olmesartan/hydrochlorothiazide (BENICAR HCT)

ANGIOTENSIN II RECEPTOR ANTAGONIST/CALCIUM CHANNEL BLOCKER COMBINATIONS

amlodipine/telmisartan
amlodipine/valsartan
amlodipine/olmesartan (AZOR)

ANGIOTENSIN II RECEPTOR ANTAGONIST/CALCIUM CHANNEL BLOCKER/DIURETIC COMBINATIONS

amlodipine/valsartan/hydrochlorothiazide
olmesartan/amlodipine/hydrochlorothiazide (TRIBENZOR)

ANTIARRHYTHMICS

amiodarone
disopyramide
flecainide
propafenone
propafenone ext-rel
sotalol

ANTILIPEMICS

Bile Acid Resins

cholestyramine
colestipol
colesevelam (WELCHOL)

Cholesterol Absorption Inhibitors

ezetimibe (ZETIA)

Fibrates

fenofibrate
fenofibric acid delayed-rel
gemfibrozil

HMG-CoA Reductase Inhibitors/Combinations

atorvastatin
fluvastatin
lovastatin
pravastatin
simvastatin ezetimibe/simvastatin (VYTORIN) rosuvastatin (CRESTOR)

Niacins/Combinations

niacin ext-rel
niacin ext-rel/simvastatin (SIMCOR)

Omega-3 Fatty Acids

omega-3 acid ethyl esters

BETA-BLOCKERS

atenolol
bisoprolol
carvedilol
labetalol
metoprolol succinate ext-rel
metoprolol tartrate
nadolol
pindolol
propranolol
propranolol ext-rel
carvedilol phosphate ext-rel (COREG CR)
nebivolol (BYSTOLIC)

BETA-BLOCKER/DIURETIC COMBINATIONS

atenolol/chlorthalidone
bisoprolol/hydrochlorothiazide
metoprolol/hydrochlorothiazide

CALCIUM CHANNEL BLOCKERS

Dihydropyridines

amlodipine
felodipine ext-rel
nifedipine ext-rel

Nondihydropyridines

diltiazem ext-rel *
verapamil ext-rel

***** Listing does not include generic Cardizem LA

CALCIUM CHANNEL BLOCKER/ANTILIPEMIC COMBINATIONS

amlodipine/atorvastatin

DIGITALIS GLYCOSIDES

digoxin
digoxin ped elixir

DIRECT RENIN INHIBITORS/DIURETIC COMBINATIONS

aliskiren (TEKTURNA)
aliskiren/hydrochlorothiazide (TEKTURNA HCT)

DIRECT RENIN INHIBITOR/CALCIUM CHANNEL BLOCKER COMBINATIONS

aliskiren/amlodipine (TEKAMLO)

DIRECT RENIN INHIBITOR/CALCIUM CHANNEL BLOCKER/DIURETIC COMBINATIONS

aliskiren/amlodipine/hydrochlorothiazide (AMTURNIDE)

DIURETICS

Carbonic Anhydrase Inhibitors

acetazolamide
acetazolamide ext-rel
methazolamide

Loop Diuretics

bumetanide
furosemide
torsemide

Potassium-sparing Diuretics

amiloride

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Thiazides and Thiazide-like Diuretics
chlorthalidone
hydrochlorothiazide
indapamide
metolazone

Diuretic Combinations
amiloride/hydrochlorothiazide
spironolactone/hydrochlorothiazide
triamterene/hydrochlorothiazide

NITRATES
Oral
isosorbide dinitrate ext-rel tabs
isosorbide dinitrate oral
isosorbide mononitrate
isosorbide mononitrate ext-rel

Sublingual/Translingual
nitroglycerin lingual spray (NITROLINGUAL)
nitroglycerin sublingual (NITROSTAT)

Transdermal
nitroglycerin transdermal

NITRATE/VASODILATOR COMBINATIONS
isosorbide dinitrate/hydralazine (BIDIL)

MISCELLANEOUS
hydralazine
methyldopa
midodrine
ranolazine ext-rel (RANEXA)

CENTRAL NERVOUS SYSTEM

ANTIANXIETY
Benzodiazepines
alprazolam
clonazepam tabs
diazepam
lorazepam
oxazepam

Miscellaneous
buspirone
clomipramine
fluvoxamine

ANTICONVULSANTS
carbamazepine
carbamazepine ext-rel
diazepam rectal gel
divalproex sodium delayed-rel
divalproex sodium ext-rel
ethosuximide
gabapentin
lamotrigine
lamotrigine ext-rel
lamotrigine orally disintegrating tabs
levetiracetam
levetiracetam ext-rel
oxcarbazepine
phenobarbital
phenytoin
phenytoin sodium extended
primidone
tiagabine
topiramate
valproic acid
zonisamide
lacosamide (VIMPAT)

ANTIDEMENTIA
donepezil
galantamine
galantamine ext-rel
memantine (NAMENDA)
rivastigmine
rivastigmine transdermal (EXELON PATCH)
memantine ext-rel (NAMENDA XR)

ANTIDEPRESSANTS
Monoamine Oxidase Inhibitors (MAOIs)
phenelzine
tranylcypromine

Selective Serotonin Reuptake Inhibitors (SSRIs)
citalopram
escitalopram
fluoxetine
paroxetine HCl
paroxetine HCl ext-rel
sertraline
fluoxetine (FLUOXETINE 60 mg)
vilazodone (VIIBRYD)
vortioxetine (BRINTELLIX)

Serotonin Norepinephrine Reuptake Inhibitors (SNRIs)
duloxetine delayed-rel
venlafaxine
venlafaxine ext-rel
desvenlafaxine ext-rel (KHEDEZLA)
desvenlafaxine ext-rel (PRISTIQ)

Tricyclic Antidepressants (TCAs)
amitriptyline
desipramine
doxepin
imipramine HCl
nortriptyline

Miscellaneous Agents
bupropion
bupropion ext-rel
mirtazapine
trazodone

ANTIPARKINSONIAN AGENTS
amantadine
benztropine
bromocriptine
carbidopa/levodopa

Boldface type indicates generic availability.

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carbidopa/levodopa ext-rel
carbidopa/levodopa orally disintegrating tabs
carbidopa/levodopa/entacapone
entacapone
pramipexole
pramipexole ext-rel (MIRAPEX ER)
ropinirole
ropinirole ext-rel
selegiline
trihexyphenidyl
rasagiline mesylate (AZILECT)
rotigotine transdermal (NEUPRO)

ANTIPSYCHOTICS

Atypicals

aripiprazole
clozapine
olanzapine
quetiapine
risperidone
ziprasidone
lurasidone (LATUDA)
quetiapine ext-rel (SEROQUEL XR)

Miscellaneous

chlorpromazine
fluphenazine
haloperidol
perphenazine
thiothixene
trifluoperazine

ATTENTION DEFICIT HYPERACTIVITY DISORDER

amphetamine/dextroamphetamine mixed salts
amphetamine/dextroamphetamine mixed salts ext-rel
dexmethylphenidate
dexmethylphenidate ext-rel
dextroamphetamine
dextroamphetamine ext-rel
guanfacine ext-rel
methylphenidate
methylphenidate ext-rel
atomoxetine (STRATTERA)
lisdexamfetamine (VYVANSE)
methylphenidate ext-rel susp (QUILLIVANT XR)
methylphenidate transdermal (DAYTRANA)

FIBROMYALGIA

milnacipran (SAVELLA)
pregabalin (LYRICA)

HYPNOTICS

Benzodiazepines

temazepam

Nonbenzodiazepines

eszopiclone
zolpidem
zolpidem ext-rel

Tricyclics

doxepin (SILENOR)

MIGRAINE

Ergotamine Derivatives

dihydroergotamine inj
dihydroergotamine spray

Selective Serotonin Agonists

naratriptan
rizatriptan
sumatriptan
sumatriptan inj
sumatriptan nasal spray
zolmitriptan
eletriptan (RELPAX)
zolmitriptan nasal spray (ZOMIG)

Selective Serotonin Agonist/Nonsteroidal Drug (NSAID) Combinations

sumatriptan/naproxen sodium (TREXIMET)

MOOD STABILIZERS

lithium carbonate
lithium carbonate ext-rel

MUSCULOSKELETAL THERAPY AGENTS

baclofen
carisoprodol
chlorzoxazone
cyclobenzaprine
dantrolene
metaxalone
methocarbamol
orphenadrine/aspirin/caffeine
tizanidine

MYASTHENIA GRAVIS

pyridostigmine
pyridostigmine ext-rel

NARCOLEPSY

armodafinil (NUVIGIL)

POSTHERPETIC NEURALGIA (PHN)

gabapentin ext-rel (GRALISE)

PSYCHOTHERAPEUTIC-MISCELLANEOUS

Alcohol Deterrents

acamprosate calcium
disulfiram

Opioid Antagonists

naltrexone

Partial Opioid Agonist/Opioid Antagonist Combinations

buprenorphine/naloxone sublingual tabs
buprenorphine/naloxone sublingual film (SUBOXONE FILM)

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Vasomotor Symptom Agents
paroxetine mesylate (BRISDELLE)

ENDOCRINE AND METABOLIC

ANDROGENS
testosterone cypionate
testosterone enanthate
testosterone soln (AXIRON)
testosterone transdermal (ANDRODERM)

ANTIDIABETICS
Alpha-glucosidase Inhibitors
acarbose

Amylin Analogs
pramlintide (SYMLINPEN)

Biguanides
metformin
metformin ext-rel

Biguanide/Sulfonylurea Combinations
glipizide/metformin

Dipeptidyl Peptidase-4 (DPP-4) Inhibitors
linagliptin (TRADJENTA)
sitagliptin phosphate (JANUVIA)

Dipeptidyl Peptidase-4 (DPP-4) Inhibitor/Biguanide Combinations
linagliptin/metformin (JENTADUETO)
sitagliptin/metformin (JANUMET)
sitagliptin/metformin ext-rel (JANUMET XR)

Incretin Mimetic Agents
dulaglutide (TRULICITY)
liraglutide (VICTOZA)

Insulins
insulin aspart (NOVOLOG)
insulin aspart protamine 70%/insulin aspart 30% (NOVOLOG MIX 70/30)
insulin detemir (LEVEMIR)
insulin glargine (LANTUS)
insulin glargine (TOUJEO)
insulin human (HUMULIN R U-500)
insulin human (NOVOLIN R)
insulin isophane human (NOVOLIN N)
insulin isophane human 70%/regular 30% (NOVOLIN 70/30)

Insulin Sensitizers
pioglitazone

Insulin Sensitizer/Biguanide Combinations
pioglitazone/metformin

Insulin Sensitizer/Sulfonylurea Combinations
pioglitazone/glimepiride

Meglitinides
nateglinide
repaglinide

Sodium-Glucose Co-transporter 2 (SGLT2) Inhibitors
dapagliflozin (FARXIGA)
empagliflozin (JARDIANCE)

Sodium-Glucose Co-transporter 2 (SGLT2) Inhibitor/Biguanide Combinations
dapagliflozin/metformin ext-rel (XIGDUO XR)

Sulfonylureas
glimepiride
glipizide
glipizide ext-rel
glyburide

Supplies
BD insulin syringes and needles
lancets
ONETOUCH ULTRA kits and test strips
ONETOUCH VERIO kits and test strips

ANTIOBESITY
Anorexiant Combinations
lorcaserin (BELVIQ)
naltrexone/bupropion ext-rel (CONTRAVE)

CALCIUM REGULATORS
Bisphosphonates
alendronate
ibandronate
risedronate (ACTONEL)
risedronate delayed-rel (ATELVIA)

Calcitonins
calcitonin-salmon

CONTRACEPTIVES
EE = ethinyl estradiol
ME = mestranol

Monophasic
10 mcg Estrogen
norethindrone acetate/EE 1/10 and EE 10 and iron (LO LOESTRIN FE)

20 mcg Estrogen
drospirenone/EE 3/20
levonorgestrel/EE 0.1/20 - Lessina
norethindrone acetate/EE 1/20
norethindrone acetate/EE 1/20 and iron
norethindrone acetate/EE 1/20 and iron - Lomedia 24 Fe
drospirenone/EE/levomefolate 3/20 and levomefolate (BEYAZ)
norethindrone acetate/EE 1/20 and iron chewable (MINASTRIN 24 FE)

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30 mcg Estrogen
desogestrel/EE 0.15/30
drospirenone/EE 3/30
levonorgestrel/EE 0.15/30 - Levora
norethindrone acetate/EE 1.5/30
norethindrone acetate/EE 1.5/30 and iron
norgestrel/EE 0.3/30 - Low-Ogestrel
drospirenone/EE/levomefolate 3/30 and levomefolate (SAFYRAL)

35 mcg Estrogen
ethynodiol diacetate/EE 1/35 - Zovia 1/35
norethindrone/EE 0.5/35
norethindrone/EE 1/35
norgestimate/EE 0.25/35

50 mcg Estrogen
ethynodiol diacetate/EE 1/50 - Zovia 1/50
norethindrone/ME 1/50

Biphasic
desogestrel/EE

Triphasic
desogestrel/EE
levonorgestrel/EE - Trivora
norethindrone/EE
norgestimate/EE
norgestimate/EE (ORTHO TRI-CYCLEN LO)

Four Phase
estradiol valerate and dienogest/ estradiol valerate (NATAZIA)

Extended Cycle
levonorgestrel/EE 0.1/20 and EE 10
levonorgestrel/EE 0.15/30
levonorgestrel/EE 0.15/30 and EE 10

Progestin Only
norethindrone

Transdermal
norelgestromin/EE

Vaginal
etonogestrel/EE ring (NUVARING)

ENDOMETRIOSIS
danazol

ESTROGENS
Oral
estradiol
estropipate
estrogens, conjugated (PREMARIN)

Transdermal
estradiol
estradiol (DIVIGEL)
estradiol (EVAMIST)
estradiol (MINIVELLE)

Vaginal
estradiol vaginal crm (ESTRACE)
estradiol vaginal tabs (VAGIFEM)
estrogens, conjugated crm (PREMARIN crm)

ESTROGEN/PROGESTINS
Oral
EE/norethindrone acetate - Jinteli
estradiol/norethindrone
estrogens, conjugated/medroxyprogesterone (PREMPHASE)
estrogens, conjugated/medroxyprogesterone (PREMPRO)

ESTROGEN/SELECTIVE ESTROGEN RECEPTOR MODULATOR COMBINATIONS
conjugated estrogens/bazedoxifene (DUAVEE)

GLUCOCORTICOIDS
dexamethasone
fludrocortisone
hydrocortisone
methylprednisolone
prednisolone sodium phosphate
prednisolone syrup
prednisone

GLUCOSE ELEVATING AGENTS
glucagon, human recombinant (GLUCAGEN HYPOKIT)
glucagon, human recombinant (GLUCAGON EMERGENCY KIT)

HYPERPARATHYROID TREATMENT, VITAMIN D ANALOGS
calcitriol (1,25-D3)
doxercalciferol
paricalcitol

PHOSPHATE BINDER AGENTS
calcium acetate
calcium acetate (PHOSLYRA)
sevelamer carbonate (RENVELA)
sucroferric oxyhydroxide (VELPHORO)

PROGESTINS
Oral
medroxyprogesterone acetate
megestrol acetate susp (MEGACE ES)
norethindrone acetate
progesterone, micronized

SELECTIVE ESTROGEN RECEPTOR MODULATORS
raloxifene
ospemifene (OSPHENA)

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THYROID AGENTS

Antithyroid Agents
methimazole
propylthiouracil

Thyroid Supplements
levothyroxine
levothyroxine(SYNTHROID)
levothyroxine - Levoxyl
liothyronine

VASOPRESSINS
desmopressin spray, tabs

MISCELLANEOUS
cabergoline
levocarnitine

GASTROINTESTINAL

ANTIDIARRHEALS
diphenoxylate/atropine
loperamide

ANTIEMETICS
dronabinol
granisetron
meclizine
metoclopramide
ondansetron
prochlorperazine
promethazine
trimethobenzamide
doxylamine/pyridoxine delayed-rel (DICLEGIS)
granisetron transdermal (SANCUSO)

ANTISPASMODICS
dicyclomine

CHOLELITHOLYTICS
ursodiol

H_2 RECEPTOR ANTAGONISTS
cimetidine
famotidine
ranitidine

INFLAMMATORY BOWEL DISEASE

Oral Agents
balsalazide
budesonide delayed-rel caps
sulfasalazine
sulfasalazine delayed-rel
budesonide ext-rel (UCERIS)
mesalamine delayed-rel tabs (LIALDA)
mesalamine ext-rel caps (APRISO)
mesalamine ext-rel caps (PENTASA)

Rectal Agents
hydrocortisone enema
mesalamine rectal susp
hydrocortisone acetate foam (CORTIFOAM)
mesalamine supp (CANASA)

IRRITABLE BOWEL SYNDROME

Irritable Bowel Syndrome with Constipation
linaclotide (LINZESS)

Irritable Bowel Syndrome with Diarrhea
alosetron (LOTRONEX)

LAXATIVES
lactulose
peg 3350/electrolytes
polyethylene glycol 3350
peg 3350/electrolytes (MOVIPREP)
peg 3350/electrolytes (SUCLEAR)
sodium sulfate/potassium sulfate/ magnesium sulfate (SUPREP)

OPIOID-INDUCED CONSTIPATION
naloxegol (MOVANTIK)

PANCREATIC ENZYMES
pancrelipase (VIOKACE)
pancrelipase delayed-rel (CREON)
pancrelipase delayed-rel (ULTRESA)
pancrelipase delayed-rel (ZENPEP)

PROSTAGLANDINS
misoprostol

PROTON PUMP INHIBITORS
esomeprazole delayed-rel (NEXIUM)
lansoprazole delayed-rel
omeprazole delayed-rel
omeprazole/sodium bicarbonate caps
pantoprazole delayed-rel
dexlansoprazole delayed-rel (DEXILANT)

SALIVA STIMULANTS
cevimeline
pilocarpine tabs

STEROIDS, RECTAL
hydrocortisone crm
hydrocortisone acetate/pramoxine foam (PROCTOFOAM-HC)

ULCER THERAPY COMBINATIONS
lansoprazole + amoxicillin + clarithromycin
bismuth/metronidazole/tetracycline (PYLERA)

MISCELLANEOUS
sucralfate

GENITOURINARY

BENIGN PROSTATIC HYPERPLASIA
alfuzosin ext-rel
finasteride
tamsulosin

Boldface type indicates generic availability.

dutasteride (AVODART)
silodosin (RAPAFLO)

URINARY ANTISPASMODICS
oxybutynin
oxybutynin ext-rel
tolterodine
tolterodine ext-rel
trospium
trospium ext-rel
mirabegron ext-rel (MYRBETRIQ)
oxybutynin gel (GELNIQUE)
solifenacin succinate (VESICARE)

VAGINAL ANTI-INFECTIVES
clindamycin crm
metronidazole
terconazole

MISCELLANEOUS
bethanechol
phenazopyridine
potassium citrate ext-rel

HEMATOLOGIC

ANTICOAGULANTS
Injectable
enoxaparin

Oral
warfarin
apixaban (ELIQUIS)
dabigatran etexilate (PRADAXA)
rivaroxaban (XARELTO)

Synthetic Heparinoid-like Agents
fondaparinux

PLATELET AGGREGATION INHIBITORS
clopidogrel
dipyridamole
dipyridamole ext-rel/aspirin (AGGRENOX)
prasugrel (EFFIENT)
ticagrelor (BRILINTA)

PLATELET SYNTHESIS INHIBITORS
anagrelide

MISCELLANEOUS
cilostazol

IMMUNOLOGIC AGENTS

ALLERGENIC EXTRACTS
ragweed pollen allergen extract (RAGWITEK)
timothy grass pollen allergen extract (GRASTEK)

DISEASE-MODIFYING ANTIRHEUMATIC DRUGS (DMARDs)
hydroxychloroquine
leflunomide
methotrexate
methotrexate (RHEUMATREX)

IMMUNOSUPPRESSANTS
Antimetabolites
azathioprine
azathioprine (AZASAN)

NUTRITIONAL/SUPPLEMENTS

ELECTROLYTES
Potassium
potassium chloride ext-rel
potassium chloride liquid

VITAMINS AND MINERALS
Folic Acid/Combinations
folic acid
folic acid/vitamin B6/vitamin B12

Prenatal Vitamins
prenatal vitamins
prenatal vitamins/DHA/docusate/folic acid (CITRANATAL 90 DHA)
prenatal vitamins/DHA/docusate/folic acid (CITRANATAL DHA)
prenatal vitamins/DHA/docusate/folic acid (CITRANATAL HARMONY)
prenatal vitamins/docusate/folic acid (CITRANATAL RX)
prenatal vitamins/docusate/folic acid + DHA (CITRANATAL ASSURE)
prenatal vitamins/folic acid + pyridoxine (CITRANATAL B-CALM)

Miscellaneous
cyanocobalamin inj
ergocalciferol (D2)
fluoride drops
fluoride tabs
multivitamins/fluoride drops, tabs
multivitamins/fluoride/iron drops, tabs
vitamin ADC/fluoride drops
vitamin ADC/fluoride/iron drops

RESPIRATORY

ANAPHYLAXIS TREATMENT AGENTS
epinephrine (AUVI-Q)
epinephrine (EPIPEN)
epinephrine (EPIPEN JR.)

ANTICHOLINERGICS
ipratropium soln
tiotropium (SPIRIVA)

ANTICHOLINERGIC/BETA AGONIST COMBINATIONS
ipratropium/albuterol soln
ipratropium/albuterol, CFC-free aerosol (COMBIVENT RESPIMAT)
umeclidinium/vilanterol (ANORO ELLIPTA)

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ANTIHISTAMINES, SEDATING
clemastine 2.68 mg
cyproheptadine
hydroxyzine HCl

ANTITUSSIVES
benzonatate

ANTITUSSIVE COMBINATIONS
Opioid
codeine/chlorpheniramine/pseudoephedrine
codeine/guaifenesin liquid
codeine/guaifenesin/pseudoephedrine
codeine/promethazine
codeine/promethazine/phenylephrine
hydrocodone/homatropine

Non-opioid
dextromethorphan/brompheniramine/ pseudoephedrine
dextromethorphan/promethazine

BETA AGONISTS
Inhalants
Short Acting
albuterol soln
albuterol sulfate, CFC-free aerosol (PROAIR HFA)

Long Acting
formoterol inhalation caps (FORADIL)
formoterol inhalation soln (PERFOROMIST)
indacaterol (ARCAPTA NEOHALER)
salmeterol xinafoate (SEREVENT)

Oral Agents
albuterol
albuterol ext-rel
terbutaline

CYSTIC FIBROSIS
tobramycin inhalation soln

LEUKOTRIENE RECEPTOR ANTAGONISTS
montelukast
zafirlukast

MAST CELL STABILIZERS
cromolyn soln

NASAL ANTIHISTAMINES
azelastine spray
olopatadine spray

PHOSPHODIESTERASE-4 INHIBITORS
roflumilast (DALIRESP)

STEROID/BETA AGONIST COMBINATIONS
fluticasone/salmeterol (ADVAIR)
fluticasone/salmeterol, CFC-free aerosol (ADVAIR HFA)
mometasone/formoterol (DULERA)

STEROID INHALANTS
budesonide inh susp
beclomethasone, CFC-free aerosol (QVAR)
budesonide (PULMICORT FLEXHALER)
fluticasone (FLOVENT DISKUS)
fluticasone, CFC-free aerosol (FLOVENT HFA)
mometasone (ASMANEX)

XANTHINES
theophylline ext-rel tabs

MISCELLANEOUS
ipratropium spray

TOPICAL

DERMATOLOGY
Acne
Oral
isotretinoin

Topical
adapalene
benzoyl peroxide
clindamycin gel, lotion, soln
clindamycin/benzoyl peroxide
clindamycin/benzoyl peroxide (BENZACLIN)
erythromycin gel 2%
erythromycin soln
erythromycin/benzoyl peroxide
sulfacetamide lotion 10%
sulfacetamide/sulfur crm, gel, lotion, pads
tretinoin
tretinoin (ATRALIN)
tretinoin gel microsphere (RETIN-A MICRO)
adapalene/benzoyl peroxide (EPIDUO)
clindamycin/benzoyl peroxide (ACANYA)
tazarotene (TAZORAC)

Actinic Keratosis
fluorouracil crm, soln 5%, soln 2%
imiquimod (ZYCLARA)
ingenol mebutate (PICATO)

Antibiotics
gentamicin
mupirocin
silver sulfadiazine

Antifungals
ciclopirox
clotrimazole
econazole
ketoconazole
naftifine (NAFTIN)
nystatin
efinaconazole (JUBLIA)
luliconazole (LUZU)

Boldface type indicates generic availability.

Your Kansas State Employees Preferred Drug List As Of January 2016

Antipsoriatics

Oral

acitretin
methoxsalen oral

Topical

calcipotriene
calcipotriene (SORILUX)

Antiseborrheics

ketoconazole shampoo 2%
selenium sulfide shampoo 2.5%

Corticosteroids

Low Potency

alclometasone crm, oint 0.05%
desonide crm, lotion, oint 0.05%
fluocinolone acetonide soln 0.01%
hydrocortisone crm 2.5%
hydrocortisone lotion 1%

Medium Potency

betamethasone valerate crm, lotion, oint 0.1%
clocortolone crm 0.1% (CLODERM)
desoximetasone crm, oint 0.05%
fluocinolone acetonide crm, oint 0.025%
fluticasone propionate crm, lotion 0.05%, oint 0.005%
hydrocortisone butyrate crm, oint, soln 0.1%
hydrocortisone valerate crm, oint 0.2%
mometasone crm, lotion, oint 0.1%
triamcinolone acetonide crm, lotion 0.025%
triamcinolone acetonide crm, lotion, oint 0.1%
hydrocortisone butyrate lotion 0.1% (LOCOID)

High Potency

betamethasone dipropionate augmented crm, lotion 0.05%
betamethasone dipropionate crm, lotion, oint 0.05%
desoximetasone crm, oint 0.25%, gel 0.05%
diflorasone diacetate crm 0.05%
fluocinonide crm, gel, oint, soln 0.05%
triamcinolone acetonide crm 0.5%

Very High Potency

betamethasone dipropionate augmented gel, oint 0.05%
clobetasol propionate crm, foam, gel, lotion, oint, shampoo, soln
diflorasone diacetate oint 0.05%
halobetasol propionate crm, oint 0.05%

Emollients

ammonium lactate 12%

Immunomodulators

tacrolimus
pimecrolimus (ELIDEL)

Local Analgesics

lidocaine patch

Local Anesthetics

lidocaine/prilocaine

Rosacea

doxycycline monohydrate (ORACEA)
metronidazole crm, gel, lotion 0.75%
metronidazole gel 1%
sulfacetamide/sulfur
azelaic acid gel (FINACEA)
ivermectin (SOOLANTRA)

Scabicides and Pediculicides

malathion
permethrin 5%

Miscellaneous Skin and Mucous Membrane

imiquimod
podofilox
penciclovir (DENAVIR)

MOUTH/THROAT/DENTAL AGENTS

Anesthetics - Topical Oral

lidocaine viscous

Steroids - Mouth/Throat

triamcinolone paste

OPHTHALMIC

Antiallergics

azelastine
cromolyn sodium
olopatadine (PATADAY)
olopatadine (PATANOL)

Anti-infectives

bacitracin
ciprofloxacin
erythromycin
gentamicin
levofloxacin
neomycin/polymyxin B/gramicidin
ofloxacin
polymyxin B/bacitracin
polymyxin B/trimethoprim
sulfacetamide oint, soln 10%
tobramycin
besifloxacin (BESIVANCE)
moxifloxacin (MOXEZA)
moxifloxacin (VIGAMOX)

Anti-infective/Anti-inflammatory Combinations

neomycin/polymyxin B/ bacitracin/hydrocortisone oint
neomycin/polymyxin B/dexamethasone
neomycin/polymyxin B/hydrocortisone susp
sulfacetamide/prednisolone phosphate 10%/0.25%
tobramycin/dexamethasone susp 0.3%/0.1%
tobramycin/dexamethasone oint 0.3%/0.1% (TOBRADEX OINTMENT)

Boldface type indicates generic availability.

tobramycin/dexamethasone susp 0.3%/0.05% (TOBRADEX ST)
tobramycin/loteprednol (ZYLET)

Anti-inflammatories

Nonsteroidal

bromfenac sodium
diclofenac sodium
ketorolac
bromfenac sodium 0.07% (PROLENSA)

Steroidal

dexamethasone sodium phosphate
fluorometholone
prednisolone acetate 1%
difluprednate (DUREZOL)
loteprednol 0.2% (ALREX)
loteprednol 0.5% (LOTEMAX)

Antivirals

trifluridine

Beta-blockers

Nonselective

levobunolol
metipranolol
timolol maleate
timolol maleate gel
timolol hemihydrate (BETIMOL)

Selective

betaxolol (BETOPTIC S)

Carbonic Anhydrase Inhibitors

Topical

dorzolamide
brinzolamide (AZOPT)

Carbonic Anhydrase Inhibitor/ Beta-blocker Combinations

dorzolamide/timolol maleate
dorzolamide/timolol maleate/preservative-free (COSOPT PF)

Carbonic Anhydrase Inhibitor/Sympathomimetic Combinations

brinzolamide/brimonidine (SIMBRINZA)

Immunomodulators

cyclosporine, emulsion (RESTASIS)

Prostaglandins

latanoprost
travoprost
tafluprost (ZIOPTAN)
travoprost (TRAVATAN Z)

Sympathomimetics

brimonidine 0.15%, 0.2%
brimonidine 0.1% (ALPHAGAN P)

Sympathomimetic/Beta-blocker Combinations

brimonidine/timolol (COMBIGAN)

OTIC

Anti-infectives

acetic acid
acetic acid/aluminum acetate
ofloxacin otic

Anti-infective/Anti-inflammatory Combinations

neomycin/polymyxin B/hydrocortisone
ciprofloxacin/dexamethasone (CIPRODEX)

Boldface type indicates generic availability.

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Kansas State
Employees Group
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06 DepFirstName5 DepLastName5 07 DepFirstName6 DepLastName6

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02 DepFirstName1 DepLastName1 03 DepFirstName2 DepLastName2
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